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AUTHOR Dryfoos, Joy G.
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ABSTRACT

"Full-service schools" present opportunities for communities to construct solutions at the local level that unite people and resources in times of stress. Among these schools are school-based health centers, youth-service centers, family-resource centers, Beacons/lighted schoolhouses, and community schools. They share the provision of community agencies in school buildings with the goal of creating comprehensive, one-stop educational and service centers. This paper describes different kinds of school-based initiatives across the United States and presents preliminary research findings on their effects. The paper also discusses the issues of governance, territorial concerns, community resistance, and funding. Suggestions for evaluating school-based programs, such as outcomes research and demonstration models, are offered. One figure is included. (LMI)

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FULL SERVICE SCHOOLS: SCHOOLS AND COMMUNITY-BASED ORGANIZATIONS FINALLY GET TOGETHER TO ADDRESS THE CRISIS IN DISADVANTAGED COMMUNITIES

Joy G. Dryfoos, 20 Circle Drive, Hastings-on-Hudson NY 10706

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A unique characteristic of United States culture is the persistence of the caring community in response to crises. No matter what devisive polemics dominate the national scene, back home the practitioners are seeking ways to work together to rescue the children in their communities. However, like the proverbial finger in the dike, without strong supports, the effort will not be sufficient.

The concept of "full service schools" is an example of our ability to construct solutions at the local level that bring forces together in times of stress. I use the term as an umbrella for a whole array of emerging models: school-based health centers, youth service centers, family resource centers, Beacons/lighted schoolhouses, and community schools (Dryfoos, 1994a). What these programs have in common is the provision of services by community agencies in school-buildings with a view toward the creation of new institutional arrangements, comprehensive "one stop" educational and service centers. The prevailing terminology for these "things" includes collaboratives, cooperatives, partnerships, and contractual relationships. Figure 1 presents my view of a feasible division of the turf in a full service school: educational components on the left lie in the domain of the educational system and health, social services, and other kinds of supportive programs lie in the domain of community agencies.

The term "full service schools" was first used in 1991 when under the leadership of Governor Lawton Chiles, the Florida legislature passed a law supporting the development of Full Service Schools (Florida Department of Health, 1991). A primary objective was to enhance the capacity of school health service programs to address teen pregnancy, risk of AIDS and other sexually transmitted diseases, and alcohol and drug abuse. The legislation required the State Board of Education and the Department of Health and Rehabilitative Services (DHRS) to jointly establish programs in local schools to serve high risk students in need of medical and social services.

Although the Florida terminology was new, the concept of providing comprehensive health and social services in schools has been around for a long time, dating back more than a century when settlement houses brought a whole array of services into school buildings to deal with the crises brought on by urbanization and immigration (Tyack 1992). As we enter a new century, the idea is reemerging in many different forms.

What's Driving this Concept?

These new arrangements are being driven by diverse social phenomena: extension of poverty, drive toward school reform, concern about adolescent health, and movement toward service integration. Much has been documented about the worsening plight of poor families and the deliterious consequences in the lives of their children. Schools become the recipients of children who are not ready to learn, who are not receiving adequate attention, and who place burdens on educators that they are not prepared to shoulder. In the opinion of the Committee for Economic Development (CED) "schools are not social service institutions; they should not be asked to solve all our nation's social ills and cultural conflicts." (Committee for Economic Development 1994). Nevertheless, CED supports the placement of social services in schools, delivered through schools, but under no circumstances funded by educational systems.

In 1991, Congress's Office of Technology Assessment issued a report on the health status of adolescents, documenting the consequences of the "new morbidities"...sex, drugs, violence, depression...and calling for greatly expanded access to comprehensive health care (Office of Technology Assessment 1991). They concluded that school-based health clinics were "a most promising recent innovation", excellent access points for young people to receive confidential primary health and social services, although they noted insufficient evaluation.

The movement toward school reform encompasses several goals that are especially relevant here: readiness for school, safe learning environments, adult literacy,and parental participation. None of these objectives can be accomplished without greatly expanding the scope of services offered in and around the school, for pre-school children as well as adults, after-school, evenings, and weekends in addition to the school day (Lavin 1992). Title 1 (formerly Chapter 1), which supports learning opportunities for disadvantaged children, has been revised to address the total school-community rather than just individual children who are pulled out of classrooms for occasional remediation.

The need to integrate services for children and families is the main theme of almost every report on social development (Melaville, Blank & Asayesh 1993; National Center for Service Integration 1993). For generations, the response to crises has been to create new categorical programs. Thus, each of the "new morbidities" has its own stream of funding, with different congressional supporters, grant requirements, administrative housing, and academic gurus. Every epidemic seems to generate its own prevention curriculum further cutting into classroom time that is needed for teaching basic skills. In any case, young people have a hard time accessing these uncoordinated sectors and have to shop around for services. The key word is fragmentation - the patchwork quilt of unrelated programs with different eligibility requirements, multiple data systems, and reimbursement mechanisms.

Connecting these movements together... assistance to impoverished families, prevention of the new morbidities,

improvement of educational outcomes, and the thrust toward more comprehensive service delivery systems ... provides the argument for full service schools. Schools are where most of the children can be found. Schools are where most of the families can establish contact with the people who educate their children and where they can obtain the help they need to be effective parents. If we could produce quality education at one site along with access to requisite health, social, and cultural services for children and families, both educational and pyscho-social outcomes should be better. Of course, to accomplish this will require major changes in both the educational and humans services establishments in the way they relate to each other and conduct their business.

Different Kinds of School-Based Initiatives

States and foundations have been the leaders in creating initiatives that bring services into schools. In some states, including Florida, California, and Kentucky, competitive grants have been awarded to school districts who must then seek partners in collaboration. In other states such as New Jersey, a community-based agency may be the lead grantee and seek partnerships with a school.More than $30 million is being spent each year in Florida on collaborative school-based projects of varying service mixes. About one third of the full service grantees include health services; many are family resource centers, case management, and/or recreational programs. (Dryfoos 1994a). The expectation is that all schools will be Full Service in a few years, gradually bringing in child care, vocational education and mental health along with health services.

California's Healthy Start Support Services for Children Act was launched in 1991 with high ideals, "to be a catalyst in a revolution that will fundamentally change for the better the way organizations work together, the way resources are allocated for children and families, the nature and location of services provided, and ultimately, the outcomes experienced by children and families" (Wagner, Golan, Shaver et al 1994 p.1.1) The $20 million initiative directly funds 40 service projects and 200 planning projects. School districts have created four types of collaborative programs: school-site family resource centers; satellite school-linked family service centers; family service coordination teams involving school personnel with project staff; and youth service programs that include school-based clinics.

The state of New Jersey Department of Human Resources pioneered the "one stop" concept with their School-Based Youth Services Program beginning in 1987. About $6 million in grants have been awarded to 29 communities to develop joint school-community agency partnerships to bring core services into school centers. Five of the grantees are community mental health centers and several are partnerships between schools and employment programs.

Kentucky's significant school reform initiative in 1988 called for the development of youth service centers in high schools with more than 20 percent of the students eligible for free school

meals. In this case, small grants are given to 122 school systems to set up a designated room in the school with a full time coordinator to oversee referrals to community agencies for health and social services and to provide on site counseling related to employment, substance abuse, and mental health. Kentucky also supports 281 family resource centers in elementary schools, which offer parent education, and refer parents to infant and child care, health services, and other community agencies. In 75 locations, a combined family and youth service center is being operated in the school. Approximately $35 million has been appropriated for FY'96 for this program (personal communication from Eric Friedlander, Kentucky Cabinet for Human Resources, January 10, 1995).

In other states, family resource centers are being supported through various state initiatives and federal grants that deliver comprehensive services on school sites, including parent education, child care, counseling, health services, home visiting, and career training.

More than half of the states have opted to use their Federal Maternal and Child Health Block grants or have created special funding initiatives to support health agencies to operate primary health care centers in schools (Brellochs & Fothergill 1994). The number of these school-based clinics has increased from 10 in 1984 to more than 700 in 1995. Typically operated by a health department, community health center, or medical school, clinics offer physical examinations, deal with minor injuries and chronic illnesses, immunizations, counseling, and lab tests (McKinney & Peak 1994). More than half dispense medications, diagnose and treat sexually transmitted diseases, and perform gynecological exams. Most provide reproductive health counseling and exams, about one third give out condoms and 15 percent distribute oral contraceptives on site. States, school districts, and sponsoring agencies set policies regarding the provision of contraceptives and other medical practices.

A few cities have launched their own full service school initiatives. In New York City, Beacons are supported by the city youth agency whereby community-based agencies create "lighted school houses", open from early morning till late at night, as well as weekends and summers (Cahill 1993). These Beacons offer a wide range of activities, depending on the neighborhood needs, including after-school recreation, educational remediation, community events, and health services. Beacons were used as the prototype for the Family and Community Endeavors part of the 1994 Crime Bill, based on the belief that offering after-school activities in high risk communities would help prevent delinquency.

In the past, the phrase community-school has been applied mainly to adult education classes in school buildings. The new generation of community-schools attempts to integrate quality education with support services. Several schools have been identified as potential models:IS218 and PS 5, operated jointly by the school district and Children's Aid Society in New York City to create a settlement house in the school; Robertson and Hanshaw operated by the school district in Modesta, California with a

Healthy Start grant; School System in Farrell, Pennsylvania, which claims to be the nation's only cradle to grave model (incorporates infant care and senior citizen activities using 57 different outside resources); and the Turner School in Philadelphia enriched by the University of Pennsylvania. What these full service community schools have in common are: restructured academic programs integrated with parent involvement and services for parents, health centers and family resource rooms, after-school activities, cultural and community activities, and open all hours and days. Each of these community schools is striving (in different ways) to become a village hub, with joint efforts from school and community agencies to create as rich an environment as possible for the children and their families.

Foundations have played major roles in creating demonstration models. The Robert Wood Johnson Foundation first supported 23 school-based clinics and recently organized Making the Grade, an initiative in 10 states selected to develop district-wide comprehensive school health programs through the departments of health and education. Dewitt-Wallace Readers Digest is supporting a cohort of university-assisted community schools, using the University of Pennsylvania program as the lead agency. The Carnegie Corporation's Turning Point initiative in states is directed toward the reorganization of middle schools including arrangements for access to health and social services in the school or in the community. Kaufman, Kellogg, and Stuart foundations also support school-based services in various forms.

It should be apparent that each version of full service schools packages the components in different ways, moving along a continuum from simple to complex adminstrative arrangements. Relocation of a contract service from one site (a public health or social service department) to another (a school building) is much less complicated than the creation of a new type of community-school where the educational system and the support interventions are completely integrated and operated collaboratively by several agencies.

Preliminary Research About Full Service Schools

Support for the concept of full service schools is strong, but even the most ardent advocates want to be assured that centralizing services in restructured schools will make a difference in the lives of the children and their families. Evaluation results are spotty, not surprising given the early stages of program development and the difficulties inherent in program research (Cook, Anson & Walchli 1993). Much of the research has been on school-based clinics. About 400 of the programs are using a special management information system, On Line, designed and managed by David Kaplan at Children's Hospital in Denver. Several years ago, the Robert Wood Johnson Foundation commissioned an evaluation of its school-based adolescent health care program (23 clinics) (Kisker, Brown & Hill 1994). The preliminary report expressed great frustration with the methodological problems inherent in school-based program outcome research. They were prohibited from using matched students from similar schools in each area as a control

group because of fear of controversy and ultimately resorted to comparing a relatively small sample of students from the program schools (a mix of users and non-users) with a small national sample of high school students. Although they found a high level of utilization of the clinics for health services, no evidence was found that the health centers led to reductions in high risk behaviors in those schools. The researchers recommended that "future research should be based on a well-matched comparison group design to obtain valid, dependable estimates of program effects" (p.174)

Several of the states (Florida, Kentucky, California) are beginning to produce reports on more comprehensive programs; in those states, grantees are mandated to participate in evaluation (Berger & Hetrick 1994; Illback 1993; Kalafat & Illback 1993; Wagner, Golan & Shaver 1994). Individual researchers around the country have published papers with some positive results (Santelli, Newcomer, 1995; Brindis, Morales, Mccarter et al 1994; Dryfoos 1994b; Godin, Woodhouse, Livingwood et al 1993; Rienzo & Button 1993) (and Kirby, 1994, unpublished) and several government publications have included summaries of preliminary research findings (Bureau of Primary Health Care 1994;Government Accounting Office 1994)

In general, programs have been successfully implemented in the communities and schools with the greatest needs and are enrolling high percentages of the student body. School clinics are most heavily utilized by the highest risk students with the greatest number of problems and no other source of medical care. More than half a million students are receiving free primary health care that is convenient, confidential, and caring. In centers with mental health personnel, substantial numbers of students and their families are gaining access to psycho-social counseling. The demand is overwhelming, especially for mental health services, substance abuse treatment, and dentistry.

Use of emergency rooms has declined in a few areas with school clinics and hospitalization rates decreased in others. Because minor illnesses such as headaches, menstrual cramps, and accidents on school property can be treated in school, absences and excuses to go home have decreased. School-based clinics have demonstrated the capacity to respond to emergencies, for example, conduct immunization campaigns and do TB screening.

Scattered evidence suggests that a few school-based clinics have had an impact on delaying the initiation of sexual intercourse (abstinence), upgrading the quality of contraceptive use, and lowering pregnancy rates, but only in programs that offer comprehensive family planning services. Large numbers of students are being diagnosed and treated for sexually transmitted diseases. In some schools, clinic users have been shown to have lower substance use, better school attendance, and lower dropout rates. Having a clinic in a school has no proven effect on non-enrollees, and rates of problem behaviors in the total school have not changed significantly. Comprehensive school-based programs for pregnant and parenting teens have demonstrated earlier access to prenatal

care and higher birth weights, lower repeat pregnancy rates, and better school retention.

Students, parents, teachers, and school personnel report a high level of satisfaction with school clinics and particularly appreciate their accessibility, convenience, confidentialiy, and caring attitudes. In family resource centers with health clinics, preventive medical care and treatment of minor illnesses are the major services sought and used. In some programs, school staff also receive health screening, nutrition, and other services.

Early reports from the more comprehensive community-schools are encouraging (Children's Aid Society 1993; Farrell School District 1993). Attendance and graduation rates are significantly higher than in comparable schools, and reading and math scores have shown some improvement. Students are eager to come to schools that are stimulating, nurturing, and respectful of cultural values. Parents are heavily involved as classroom aides, advisory board members, in classes and cultural events, with case managers and support services.

Although the models mentioned here - clinics, centers, community schools - have many differences, research has yielded a number of common components of successful programs. School and community people (local agencies, parents, leaders) join together to develop a shared vision of new institutional arrangements. An extended planning process starts off with a needs assessment to insure that the design is responsive to the requirements of the students and their families.

The configuration of support services brought in from the outside is dependent on what already exists in the school in the way of health, social services, and counseling. The building principal is instrumental in the implementation and smooth operation of full service schools. He/she not only acts as the leader in school restructuring, he must also be the prime facilitator for assuring smooth integration of the outside partners into the school environment. Active visible support of the program is essential. Adequate space must be made available, with security and maintenance.

In addition to the principal, successful programs rely on a full-time coordinator or program director. All personnel are trained to be sensitive to issues related to youth development, cultural diversity, and community empowerment. Bilingual staff are essential. A designated space such as a clinic or a center in a school acts an anchor, or even a magnet, for bringing in other services from the community. Perhaps the most important effect of entering into the full service schools process is the capability of the new entity to bring new resources into the school building.

Issues in Replication

Governance: As would be expected, the more complex the model, the more demanding the administrative arrangements. The mounting rhetoric calls for sophisticated collaborative organizations, whereby school systems and community agencies leave behind their parochial loyalties and pitch in together to form a new kind of union. In reality, most of the emerging models have one designated

lead agency. If it is the school system, as in Modesta, California, it dispenses its Healthy Start grant to a whole array of public and voluntary agencies through contractual relationships. In other places such as New Jersey, community agencies may be direct grantees and enter schools through a memorandum of agreement. But in neither case is governance changed.

The first evaluation of New Beginnings in San Diego, (a multi-agnecy program that operates a family resource center in Hamilton School) warns that it is "difficult to overestimate the amount of time collaboration takes". The participants discovered that it was easier to get agencies to make "deals" (sign contracts to relocate workers) than to achieve major changes in delivery systems. Staff turnover, family mobility, fiscal problems, and personality issues were cited as some of the barriers to change.

Turf: An issue related to governance is turf: who owns the school building? When a whole new staff working for an outside agency moves on to school property, many territorial concerns arise. What role does the school nurse play in the school-based clinic? Why not hire more school social workers if family counseling and case management is needed? Issues arise over confidentiality, space, releasing students from classes, and discipline. It takes time and energy, and particularly, skilled principals and program coordinators to work through appropriate policies and practices.

Controversy: In the earlier years, communities and school boards expressed resistance to the idea of school-based clinics, and in some places, just the idea of using the school building for anything but educational purposes was perceived as controversial. Experience throughout the country has shown that this resistance has dissipated rapidly with the availability of state and foundation grants for comprehensive school health and social services. The extensive local needs assessments and planning prior to program development has equipped parents and school personnel with the necessary data to convince decision-makers and educate the media about the importance of integrating services in the school.

Funding: The annual cost for these full service school models ranges from $75,000 for Kentucky's Youth and Family Service Centers to $800,000 for the most comprehensive community-school. School-based clinics average about $150,000 per year, not including large amounts of in-kind and donated goods and services.The cost for a clinic user is about $100 per year while the incremental cost for a student in a community-school might be about $1,000. As we have seen, states are major funders of these initiatives and even with looming budget cuts, are moving ahead to support more comprehensive school-based programs. Except for a recent initative in the Bureau of Primary Health Care, no federal grants go directly to communities and schools for integrated services. However, the full service school concept has been recognized in significant new legislative endeavors including the crime bill, Title 1, versions of health reform, and the new Empowerment Zone grants. Federal regulations could be changed to facilitate the increased use of categorical dollars, for example from special education, HIV

prevention, substance abuse, and mental health programs. Medicaid is already being accessed in many schools although providers experience difficulties both with eligibility determination and reimbursement procedures. The advent of managed care adds to the complexity, with providers struggling to establish either fee-for-service or capitation contracts with managed care providers. State and federal health care reform legislation should guarantee that school-based centers can become "essential community providers" and enrollees in managed care plans can obtain mental health, health education, and other preventive services within these plans.

How Can We Prove That These Things Work?

The emergence of these diverse school-based programs creates a rich territory for researchers interested in tracking complex models. It will not be easy to sort out impacts, nor to be able to attribute any particular effect to a specific program component in comprehensive programs.

Outcome research:A major research effort should be launched to determine how these various models affect adolescents. Outcomes of interest could include education (achievement, attendance, graduation), health (resistance to "new morbidities"), mental health (not depressed or stressed out), and self-sufficiency (higher education or job). Methodology should encompass long-term as well as short-term measures and be designed to focus on the issues discussed above and other questions such as:

* Are outcomes better for students who attend schools that have designated centers providing comprehensive health, mental health, and social services?
* Is it more effective to provide services on school sites or can the outcomes be improved through school-linked services with strong referral mechanisms to community agencies?
* Are the results different in different kinds of schools (academic vs. vocational); communities (poverty vs middle income; urban vs rural); level of integration (segregated vs non-segregated)?
* Is quality of service a factor (staff qualifications, protocols, hours open, arrangements for back-up care)?
* Does cost (dollars per visit) make a difference?
* Is the impact enhanced when educational restructuring is combined with strong support services in community-schools models?
* What is the most efficient division of labor between the school system and community agencies?
* What are the advantages (costs and effectiveness) of providing health and social services in schools compared to other means of providing preventive services to adolescents such as private physicians offices, community health centers, health maintenance organizations, youth centers, hospital outpatient and emergency departments or compared to not providing those services anywhere?

Demonstration models:One could envision an RFP from a government agency or foundation that would award grants for demonstration models requiring school/community partnerships and

formative evaluations. Some of the ideas to be incorporated in the demonstrations might include:

* Full service schools: plans that focus equally on both sides of the equation: quality education and support services (Figure 1).

* New division of labor: shifting the responsibility for all the non-academic offerings from the school system to one or more outside community agencies. This implies offering all the social skills that go with health education and promotion (sex, drugs, violence, AIDS, suicide, nutrition) in an after-school program (or adding another period to the school day), with group and individual counseling, and access to health services, and putting the didactic information in the appropriate school curriculum of science, social science, and even English.

* Rural models: creation of district-wide access to comprehensive services with centralized administrations that use teams, and mobile units to cover small schools. Creative solutions to transportation problems.

* Case management: develop school-based centers built around case management models. Develop systems for tracking students from K-12.

* Disabled and handicapped: create centers that take over the responsibility for medical and psychological services for disabled and handicapped students, incorporating special education personnel into clinic models.

* Architecture: support consultation to school districts for building new schools or modifying old ones to become full service schools, e.g. incorporating clinics and family resource centers.

* Youth agencies/settlement houses: encourage national youth agencies/settlement houses to invent models for bringing services into schools, using their own special expertise on youth development, experiential learning, after-school recreation.

The Future

The full service school is a home-grown product with many variants, developed at the local level by committed individuals who come together from diverse domains to try to build more responsive institutions. We don't even know how many schools now have established partnerships with human services agencies, but the number is clearly growing. Relatively small investments by state governments and foundations enable innovative leaders to better use existing categorical resources to relocate personnel and devise more integrated delivery systems. Going to scale, broadly replicating full service schools in disadvantaged communities, will require more federal resources, not likely to be made available this year. Advocacy groups are forming at the state and national level to push for this new movement.

Research will confirm that combining prevention interventions with school restructuring will create stronger institutions and schools will become neighborhood hubs, places where children's lives are enhanced and families want to go. We know that the school's role is to educate and the family's responsibility is to raise the children. Many of today's parents need assistance in accomplishing that task. Full service schools may be an effective

arrangement for achieving school, family, and societal goals.

Figure 1

COMPONENTS OF
FULL SERVICE SCHOOLS

QUALITY EDUCATION
PROVIDED BY SCHOOLS
effective basic skills
individualized instruction
team teaching
cooperative learning
school-based management
healthy school climate
alternatives to tracking
parent involvement
effective discipline

PROVIDED BY SCHOOLS OR
COMMUNITY AGENCIES
comprehensive health education
health promotion
social skills training
preparation for the world
of work, life planning

SUPPORT SERVICES
PROVIDED BY COMMUNITY AGENCIES
health screening and services
dental services
family planning
individual counseling substance
abuse treatment
mental health services
nutrition/weight management
referral with follow-up
basic services: housing, food,
clothes
recreation, sports, culture
mentoring
family welfare services
parent education, literacy
child care
employment training/ jobs
case management
crisis intervention
community policing
laundry facilities

REFERENCES

Berger,N. & Hetrick, M. (1994) The evaluation of Florida's Full Service Schools:The 1992-1993 evaluative report and the future. Paper presented at Conference on School Health and Full Service Schools, St. Petersburg, Florida.

Brellochs, C., & Fothergill, K. (1993). Special report: Defining school-based health center services. (Report). New York, NY: School Health Policy Initiative, Center for Population and Family Health, Columbia University School of Public Health.

Brindis, C., Morales, S., McCarter, V., Dobrin, C., & Wolfe, A. (1994) An evaluation study of school-based clinics in California: Major findings, 1986-1991. San Francisco, CA: Center for Reproductive Health Policy Research, University of California.

Bureau of Primary Health Care (1993). School-based clinics that work. Washington DC: DHHS Public Health Services, Health Resources and Services Administration.

Cahill, M. (1993). A documentation report on the New York City Beacons initiative. New York, NY: The Youth Development Institute, The Fund for the City of New York.

Children's Aid Society (1993).Building a community school: a revolutionary design in public education. New York: Children's Aid Society.

Committee for Economic Development (1994) Putting learning first: governing and managing the schools for high achievement. New York: Research and Policy Committee, CED.

Cook, T., Anson, A., & Walchli, S. (1993). From causal description to causal explanation: Improving three already good evaluations of adolescent health programs. In S.Millstein, A. Peterson, & E. Nightengale (eds.) Promoting the health of adolescents: New directions for the twenty-first century (pp.339-374), New York, NY: Oxford University Press.

Dryfoos, J. (1994a) Full service schools: a revolution in health and social services for children, youth, and families. San Francisco, CA: Jossey-Bass.

Dryfoos, J. (1994b).School-linked services and community schools. New York, NY: Report to Dewitt Wallace-Reader's Digest Fund.

Farrell Area School District (1993) A tradition of care and education for all: Prescription for America. Farrell Avenue School

District. Flyer.

Florida Department of Health and Rehabilitative Services and Department of Education (1991). Request for program designs for supplemental school health programs. (Instructions) Tallahassee,

Godin, S., Woodhouse, L., Livingwood, W., & Jacobs, H. (1993). Key factors in successful school-based clinics. NMHA Prevention Update, 4(1) 3.

Government Accounting Office (1994). School-based health center can expand access for children. Washington DC: US Government Accounting Office GAO/HEHS -95-35.

Illback, R. (1993)Formative evaluation of the Kentucky Family Resource and Youth Service Centers: A descriptive analysis of program trends. Louisville Ky: REACH of Louisville.

Kalafat, J.& Illback R. (1993)Implementation evaluation of the Family Resource and Youth Service Centers: A qualitative analysis. Louisville KY: REACH of Louisville.

Kisker,E., Brown, R. & Hill, J. (1994) Healthy caring: Outcomes of the Robert Wood Johnson Foundation's school-based adolescent health care program. Princeton NJ: Mathematica Policy Research.

Lavin, A., Shapiro, G. & Weill, K. (1992). Creating an agenda for school-based health promotion: a review of selected reports. Cambridge, MA: Harvard School of Public Health.

Melaville, A, Blank, M. & Asayesh, G.(1993).Together we can: A guide for crafting a profamily system of education and human services. Washington DC: U.S. Government Printing Office.

Mckinney, D. & Peak, G. (1994). School-based and school-linked health centers: Update 1993. Washington DC: Center for Population Options.

National Center for Service Integration(1993) Service Integration: An Annotated Bibliography, Information Clearinghouse, National Center for Children in Poverty, Columbia University.

Office of Technology Assessment, U.S. Congress (1991). Adolescent health-volume I: summary and policy options(OTA-H-468) Washington DC: U.S. Government Printing Office.

Rienzo, B., & Button, J. (1993). The politics of school-based clinics: A community-level analysis. Journal of School Health, 63(6), 266-272.

Tyack, M. (1992).Health and social services in public

schools:Historical perspectives. The Future of the Children, 2:1, 19-31.

Wagner, M. & Shaver, D. (1994) California's Health Start school-linked services initiative: The changing role of schools. Paper presented to the American Educational Research Association annual meeting, New Orleans, Louisiana, April, 1994.

Wagner, M., Golan, S., Shaver, L., Wechsler, M. & Kelley, F. (1994)A Healthy Start for California's Childrn and Families: Early Findings from a Statewide Evaluation of School-Linked Services. Menlo Park, CA: SRI International.